Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 24, 2017	2016_188168_0020	029573-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA VINK (168), LESLEY EDWARDS (506), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 5, 28, 2016, November 1, 3, 4, 9, 10, 14, 2016, December 12, 13, 14, 22, 2016, January 3, 2017, February 13, 17, 2017 and March 21, 2017.

This complaint inspection was conducted related to medication incidents and adverse drug reactions, administration of drugs, duty to protect and reporting certain matters to the Director.

During the course of the inspection, the inspector(s) spoke with former and current Executive Directors (ED), former Directors of Care (DOC), the Assistant Director of Care (ADOC), the Medical Director, an attending physician, the restorative care coordinator, pharmacist, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), the Director of Health and Wellness (retirement home), Regional Manager of Education and Resident Services, Retirement Coordinator, Food Service Manager (FSM), Regional Manager of Clinical Services, an external vendor, family members and residents.

During the course of this inspection the inspectors: observed the provision of care and services including medication administration, reviewed clinical health records and other records including but not limited to: relevant policies and procedures, employee files, staff training and orientation records, staffing schedules, meeting minutes, complaints and medication incidents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Telfer Place is a long term care home with a licensed capacity of 45 beds.
Executive Director #618 verified the staffing pattern for the home included at least one RN (not including the Director of Care) on duty and present at all times, in addition to a mix of RPNs and PSWs to meet the nursing and personal care needs of residents.

Interview with ED #618 identified that currently the home has a sufficient number of RNs on staff to fill all RN positions according to the staffing plan; however, there were occasions when due to vacation coverage or illness the home has vacant shifts which needed to be filled.
It was identified that the home consistently offers additional shifts and overtime to their RNs to fill these vacant shifts; however, when the RNs employed by the home are unwilling or unable to work the vacant shifts the home may fill the shifts with RPNs employed by the home with a RN on call, or with RNs employed by an employment agency, in an effort to provide RN coverage 24 hours a day seven days a week.
The Registered Nurses Staffing Schedules were provided for approximately six months in 2016, on request.
It was identified that the home was able to supplement their staffing levels with the new graduate initiative program.
A review of the schedules, by scheduler #616, confirmed that over the identified time period there were over 25 occasions when the only RN in the home was an agency RN and seven occasions when there was only an RPN, employed by the home, in the building with a RN, on call.
It was verified by ED #618 that the agency RNs were not members of the regular nursing staff and that no circumstances were present, to their knowledge, which permitted an exception to the requirements of section 8(3), by virtue of section 45 of the Regulation.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is at least one registered nurse who is an employee of the licensee and is a member of the regular nursing staff on duty and present at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that screening measures, including criminal reference checks, were conducted in accordance with the regulations before they hired staff.

Ontario Regulation 79/10 section 215(1)(2) identifies that the section applies where a criminal reference check is required before a licensee hires a staff member, as set out in subsection 75(2) of the Act and that the criminal reference check must be conducted by a police force and conducted within six months before the staff member is hired by the licensee. Subsection 75(3) of the Act identifies that a staff member who is agency staff is considered hired when he or she first works in the home.

RN's #610, #609 and #605 worked at the long term care home, as agency registered nurses, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.
RN #610 worked occasionally at the home in 2015 and 2016.
RN #609 worked occasionally at the home from 2014 until 2016.
RN #605 worked only one shift, independently at the home in 2016.
Interview with the ADOC identified that the RNs provided direct care to residents as part of their duties during the shifts they worked at the home.
Former DOC #620 identified that it was the expectation that the employment agency completed all of the required screening, for any staff they arranged to work at the home.
The ADOC verified that they had not obtained criminal reference checks from the employment agency that employed the RNs nor had they requested that the staff provide verification of a completed criminal reference check before they performed their responsibilities.

Ontario Regulation 79/10 section 234(1)3 identifies that the licensee is required to ensure that a record is maintained for each staff member of the home that includes the staff member's criminal reference check, as required under subsection 75(2) of the Act.

Screening measures, including criminal reference checks, were not conducted as required. [s. 75. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that screening measures are conducted in accordance with the regulations before they hired staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home received training as required. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

RNs #610 and #607 were identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the licensee and an employment agency or other third party.

Executive Director #618 identified that to their knowledge the home utilized the services of employment agencies to fill vacant shifts including coverage of vacation time of regular employees of the home and/or to cover sick calls.

A. RN #610 worked at the home, beginning in 2015, as an agency nurse, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.
A review of orientation and training records, provided by the home, for RN #610 identified that they did not receive training in the areas of: Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control.
Interview with RN #607, who completed the orientation with RN #610, was shown a copy of the agency RN's "Orientation Checklist" and identified that they could not specifically recall the orientation. It was verified that during the orientation process RN #607 would have followed the checklist and that the specific items identified were not recorded as being completed according to the document provided. To the recall of RN #607, they were not aware of any additional handouts or information provided to agency staff as part of the orientation process, in 2015.
The ADOC reviewed the employee records for RN #610 and verified that the orientation and training records available did not include that all of the mandatory training was completed.

Orientation and training was not provided as required for RN #610 in the area of Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control, prior to providing their services.

B. According to orientation records RN #609 worked at the home, beginning in 2014, as an agency nurse, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.
The ADOC identified that the home continued to utilize the services of the RN intermittently, as required until 2016.
A review of the initial orientation, from 2014, provided by the home, for RN #609 identified that they did not receive training in the areas of: Residents' Bill of Rights, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control.
The ADOC reviewed the employee records for RN #609 and verified that the orientation records available did not include that all of the mandatory training was completed in 2014.
Interview with the ADOC identified that in the summer of 2016, the role of staff development was added to their position. At this time they implemented an agency staff training booklet, in addition efforts were made to provide retraining to all regular agency staff for the mandatory training.
Training records, identified that RN #609 was retrained and provided with a hard copy of the required training in 2016.
This training was completed with the support of DOC #620.
A review of the sign off records, training materials and interview with the ADOC identified that the RN was provided with all required training, when they were retrained in 2016.

Orientation was not initially provided as required for RN #609 in the area of Residents' Bill of Rights, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control, prior to providing their services.

Interview with former DOC #619 who was responsible for staff development, identified that in 2015, agency staff would have received a minimum of a four hour orientation, with a RN from the home, to complete an orientation checklist. DOC #619 also indicated that the home implemented a "booklet" for agency staff, which included all mandatory training to be completed, along with a sign back form for the agency staff to complete and return

to the home, for retention as a record that the training was complete; however, the exact time of this implementation was unknown.

The training was not completed as required. [s. 76. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff at the home receive training as required and that no person mentioned in subsection (1) performs their responsibilities before they receive training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included:
the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

A. Review of the home's complaint logs identified that there was a complaint made by resident #011's substitute decision maker (SDM).
The Client Service Response (CSR) form did not include the date which the complaint was received.
The CSR form did include the nature of the complaint and indicated that the form would be forwarded to the ADOC for follow-up.

The CSR form did not include a record of the action taken to resolve the complaint, including dates, time frames for actions or the final resolution for the complaint, nor dates on which a response was made to the complainant.
Interview with the ADOC on December 13, 2016, confirmed that they did not recall the complaint being forwarded to them and did not complete the CSR form.
Interview with the Regional Manager of Education and Resident Services, who was the acting ED at the time of the complaint, confirmed that they forwarded this complaint to the ADOC for completion and that it was the expectation that the relevant manager would complete the form before returning it to the ED.

B. A complaint was made by resident #106's SDM.
The CSR form did include the nature of the complaint; however, there was no mention of the actions taken to resolve the complaint, including dates, time frames for actions and the final resolution for the complaint, nor did not include dates on which a response was made to the complainant.
Interview with the Regional Manager of Education and Resident Services, who was the acting ED at the time of the complaint, confirmed that they forwarded this complaint to the ADOC and the FSM for follow-up and completion.
Interview with the ADOC on December 13, 2016, revealed that they could not recall the CSR form.
Interview with the FSM on December 14, 2016, verified that they recalled a discussion regarding the concern at the management meeting; however, could not recall a CSR form for the issue.

C. An email complaint was sent to the ADOC in 2016, from staff regarding the care and services provided to residents by agency staff at the home.
The ADOC received the complaint and responded to RN #612, the following day, by email indicating that the concern would be forwarded to DOC #103.
A review of the home's complaints log did not include a CSR form regarding the concerns identified.
Interview with DOC #103 confirmed that they did not recall any concerns regarding care and services provided to the residents by agency staff at the home.
Interview with the ADOC on February 18, 2017, confirmed that they did not complete a CSR form for the concerns identified in the email and confirmed that the home did not follow the complaints process.

The home did not comply with the requirements for the management of complaints. [s. 101. (2)]

2. The licensee failed to ensure that documented complaints were reviewed and analyzed for trends at least quarterly.

A review of the home's Professional Advisory Committee meeting minutes for April and July 2016, were completed.
Client Service Response (CSR) forms were identified in the meeting minutes; however, the meeting minutes did not include a review of the complaints nor were the complaints analyzed for trends.
Interview with the Regional Manager of Education and Resident Services, who was the acting ED in July 2016, confirmed that the complaints were not reviewed and analyzed for trends at the Professional Advisory Committee meeting as per the process in the home.

The complaints were not reviewed and analyzed for trends as required. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes: the date the complaint is received;
the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response is provided to the complainant and a description of the response; and any response made in turn by the complainant and to ensure that documented complaints are reviewed and analyzed for trends at least quarterly, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident was reported to the resident's substitute decision maker (SDM) and the pharmacy service provider.

Review of the home's medication incidents identified five medication incidents, involving residents #002, #003, #004, #005, and #006 that took place on an identified date in 2016, were documented as medication omissions by RN #631.
The medication incidents were discovered by the following shift and medication incident reports were completed.
The medication incident reports did not include information that the residents' SDMs were notified of the incidents nor that the pharmacy was informed of the omissions.
Interview with the home's pharmacist, who regularly visits the home, verified they did not always receive medication incidents from the home. Medication incidents were identified to be consistently reported when they were a pharmacy error or an adverse event. The pharmacist identified that to their knowledge the home managed medication errors, by the nursing staff internally.
Interview with the ADOC on December 12, 2016, confirmed that the five identified medication incidents were not reported to the residents' SDMs or pharmacy as required. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident which involves a residents is reported to the resident's substitute decision maker (SDM) and the pharmacy service provider, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience. O. Reg. 79/10, s. 234 (1).
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession. O. Reg. 79/10, s. 234 (1).
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act. O. Reg. 79/10, s. 234 (1).
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: where applicable, verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she was a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.

It was identified by ED #618 that the home had a staffing plan and a minimum staffing level that they would maintain to provide care and services to the residents. When the home was unable to achieve this level, with staff employed by the home, they utilized the services of employment agencies, who held contracts with the home, to provide professional nursing services on request.

There was a contract between the home and an agency which identified that all staff provided would be in good standing with the College of Nurses (CNO) and that the company would endeavor to provide proof of insurance, WSIB (Workplace Safety and Insurance Board) and proof of registration/license upon request.

A. Agency RN #610 worked at the home and was responsible to provide direct care to residents intermittently in 2015 and 2016. The home had not requested proof of registration/license, from the agency or the staff member, nor had they verified the nurse's standing with the CNO by other means such as the CNO "Find a Nurse" website as identified by the ADOC. The home did not maintain a record of the RNs verification of current registration with the CNO.
B. Agency RN #609 worked at the home and was responsible to provide direct care to residents intermittently from 2014, until 2016. The home had not requested proof of registration/license, from the agency or staff member, nor had they verified the nurses standing with the CNO by other means such as the CNO "Find a Nurse" website as identified by the ADOC. The home verified the nurse's status with the CNO, in 2016 and at that time maintained documentation to support that the nurse was "entitled to practise with no restrictions".

Interview with the ADOC verified the past practice, when they utilized the services of the agencies to provide registered nursing staff, that they had not requested proof of registration/license with the CNO nor checked the status for the specific registered nursing staff who worked in the home as placed by the employment agency, as it was assumed that the agency screened staff as outlined in their contact. [s. 234. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member: where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession, to be implemented voluntarily.

Issued on this 25th day of May, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.